Washington State DEPARTMENT OF SOCIAL & HEALTH SERVICES

EMERGENCY MEDICAL CONDITION DETERMINATION

CASE NAME	
CASE NUMBER	DATE

TO: Medical Assistance Administration
Medical Authorization and Consultation Section (MAC)
Mail Stop: 45540

ATTN: DR. _____

FROM: _____
FINANCIAL WORKER'S NAME

_____ Community Services Office (CSO), Mail Stop: _____

Please determine whether the following applicant has an emergency medical condition as required for medical coverage under the Limited Casualty Program - Medically Indigent and Undocumented Alien Program.

SECTION I: COMPLETED BY FINANCIAL WORKER

1. PATIENT NAME	2. BIRTHDATE	3. DOCUMENTATION ATTACHED	4. ONSET DATE OF MEDICAL CONDITION
		☐ Yes ☐ No	

5. Patient was:
☐ Hospitalized, date(s): _____; hospital: _____

☐ Treated by physician, date(s): _____; physician: _____

6. MEDICAL CONDITION

SECTION II: COMPLETED BY CONSULTANT

Please respond within 5 days as this application cannot be processed until a determination is made.

1. Is the patient's condition an emergency medical condition? ☐ Yes ☐ No

2. Is further information necessary before a determination can be made? ☐ Yes ☐ No
If a specialist's opinion is necessary, what is the specialty?

MEDICAL CONSULTANT	DATE	TELEPHONE NUMBER

DISTRIBUTION: White - Financial Record Yellow - MAC Pink - Financial Worker Tickler